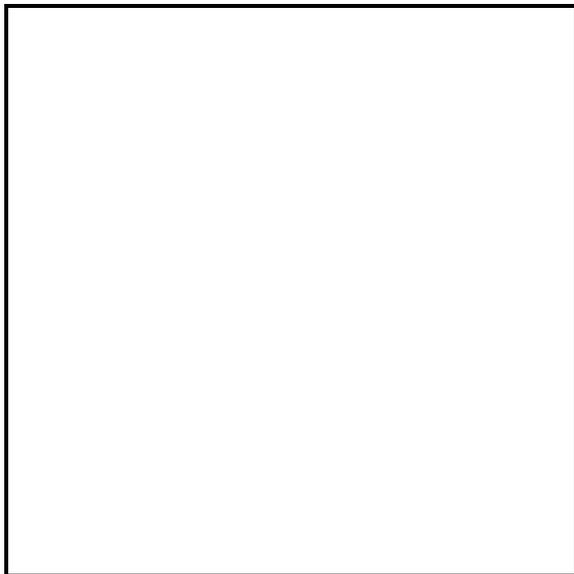
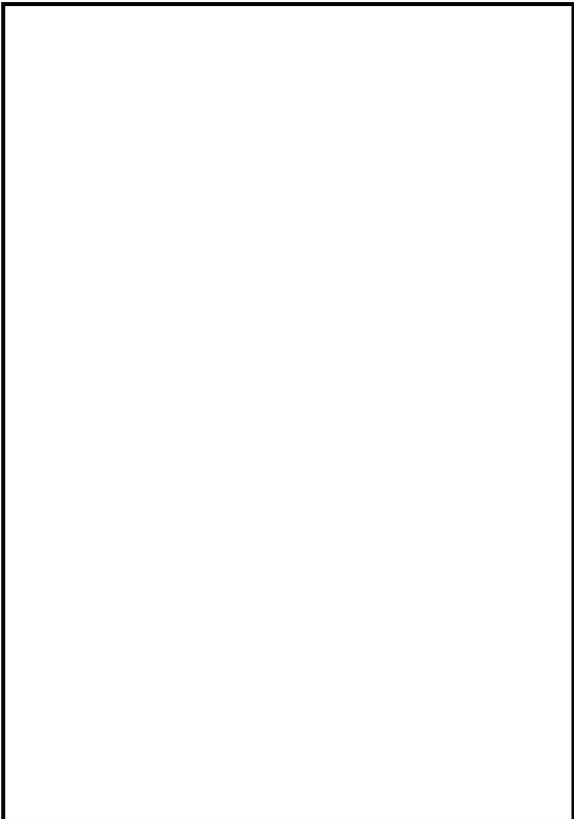


SCENE DIAGRAM

Instructions

- 1) Use figure at right for a rectangular room, and use figure below right for a square room. Use a supplementary page to draw an unusually shaped room.
- 2) Indicate the following on the diagram (check when done):
 - ___ North direction
 - ___ Windows and doors
 - ___ Wall lengths
 - ___ Ceiling height: _____
 - ___ Location of furniture
 - ___ Location of crib or bed
 - ___ Body location when found
 - ___ Location of other objects in room
 - ___ Location of heating and cooling supplies and returns
- 3) Make additional notes or drawings in available spaces as needed.
- 4) Check all that apply about heat source:
 - ___ Gas furnace or boiler
 - ___ Electric furnace or boiler
 - ___ Forced air
 - ___ Steam or hot water
 - ___ Electric baseboard
 - ___ Other: _____
 - ___ None
- 5) Complete the following:
 - Thermostat setting: _____
 - Thermostat reading: _____
 - Actual room temperature: _____
 - Outside temperature: _____



**SUDDEN UNEXPLAINED INFANT DEATH
INVESTIGATION REPORT FORM (SUIDIRF) 3.96**

Case number _____

Infant's full name _____ Age _____ DOB _____
 Home address _____ Race _____ Sex _____
 City, state, zip _____ Ethnicity _____
 County _____ SS# _____
 Police complaint number _____ Police department _____

I. CIRCUMSTANCES OF DEATH

Action	Date	Time	By whom (person or agency)	Remarks
ME/C notified				Receipt by:
NOK notified				Person:
Scene visit				<input type="checkbox"/> ME/C staff <input type="checkbox"/> Other agency <input type="checkbox"/> Not done
Scene address				
Condition of infant when found	<input type="checkbox"/> Dead (D) <input type="checkbox"/> Unresponsive (U) <input type="checkbox"/> In distress (I) <input type="checkbox"/> NA (N)			
Sequence of events before death:				

Event	Date	Time	Location (street, city, state, county, zip code)	
Injury				
Discovery				
Arrival			Hospital:	Transport by:
Actual death			<input type="checkbox"/> On scene (S) <input type="checkbox"/> Emergency room (E) <input type="checkbox"/> Inpatient (I) <input type="checkbox"/> En route or DOA (D) <input type="checkbox"/> During surgery (O)	
Pronounced dead			By whom: License #:	Where:

Event	Date	Time	By whom (person)	Remarks
Infant placed				Place:
Known alive				Place:
Infant found				Place:
First response				Type:
EMS called				From where:
EMS response			Agency:	
Police response			Agency:	

Place of fatal event <input type="checkbox"/> Witness in room or area (W) or <input type="checkbox"/> Unwitnessed (U) <input type="checkbox"/> At own home (H) or <input type="checkbox"/> Away from home (A) <input type="checkbox"/> Indoors (I) or <input type="checkbox"/> Outdoors (O) <input type="checkbox"/> In vehicle (V) or <input type="checkbox"/> Not in vehicle (N)	Describe type of place:
--	-------------------------

II. BASIC MEDICAL INFORMATION

Health care provider for infant:		Phone:			
Medical history	<input type="checkbox"/> Not investigated (X) <input type="checkbox"/> Unk (U) <input type="checkbox"/> No past problems (N) <input type="checkbox"/> Medical problems (P)				
Medical source	<input type="checkbox"/> Physician (P) <input type="checkbox"/> Other health care provider (H) <input type="checkbox"/> Other (O) <input type="checkbox"/> Medical records (M) <input type="checkbox"/> Family (F) <input type="checkbox"/> None (N)				
Specific infant medical history		Yes	No	Unk	Remarks
A. Problems during labor or delivery Birth hospital: Birth city and state:					
B. Maternal illness or complications during pregnancy Number of prenatal visits:					
C. Major birth defects					
D. Infant was one of multiple births (e.g., a twin) Birth weight: Gestational age at birth (weeks):					
E. Hospitalization of infant after initial discharge					
F. Emergency room visits in past 2 weeks					
G. Known allergies					
H. Growth and weight gain considered normal					
I. Exposure to contagious disease in past 2 weeks					
J. Illness in past 2 weeks					
K. Lethargy, crankiness, or excessive crying in past 48 hours					
L. Appetite changes in past 48 hours					
M. Vomiting or choking in past 48 hours					
N. Fever or excessive sweating in past 48 hours					
O. Diarrhea or stool changes in past 48 hours					
P. Infant has ever stopped breathing or turned blue					
Q. Infant was ever breast-fed					
R. Vaccinations in past 72 hours					
S. Infant injury or other condition not mentioned above					
T. Deceased siblings					
Diet in past 2 weeks included: <input type="checkbox"/> Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Cow's milk <input type="checkbox"/> Solids Date and time of last meal: Content of last meal:					
Medication history	<input type="checkbox"/> Not investigated (X) <input type="checkbox"/> Unk (U) <input type="checkbox"/> Rx (P) <input type="checkbox"/> OTC (O) <input type="checkbox"/> Home remedies (H) <input type="checkbox"/> None (N)				
Emergency medical treatment	<input type="checkbox"/> None (N) <input type="checkbox"/> CPR (R) <input type="checkbox"/> Transfusion (T) <input type="checkbox"/> IV fluids (F) <input type="checkbox"/> Surgery (S)				
Medicine names and doses; if prescription, include Rx number, Rx date, and name of pharmacy:		Describe nature and duration of resuscitation and treatments used to revive infant:		Describe any known injuries or marks on infant created or observed during resuscitation or treatment:	

III. HOUSEHOLD ENVIRONMENT

Action	Yes	No	Unk	Remarks
A. House was visited				
B. Evidence of alcohol abuse				
C. Evidence of drug abuse				
D. Serious physical or mental illness in household				
E. Police have been called to home in past				
F. Prior contact with social services				
G. Documented history of child abuse				
H. Odors, fumes, or peeling paint in household				
I. Dampness, visible standing water, or mold growth				
J. Pets in household				
Type of dwelling:		Water source:		Number of bedrooms:
Main language in home:		Estimated annual income:		On public assistance ___ Yes ___ No
Number of adults (≥18 years of age): ___ and children (<18 years of age): ___ living in household. Total = ___ people.				
Number of smokers in household:		Does usual caregiver smoke? ___ Yes ___ No ___ Unk		If yes, ___ cigarettes/day
Maternal information	Age:	___ Married (M) ___ Divorced (D) ___ Single (S) ___ Widowed (W)	Cohabiting w/ partner: ___ Yes ___ No	Education (years): ___ Employed (E) ___ Not employed (N)

IV. INFANT AND ENVIRONMENT

<input type="checkbox"/> In crib (C) <input type="checkbox"/> In bed (B) <input type="checkbox"/> Other (O)		<input type="checkbox"/> Sleeping alone (A) <input type="checkbox"/> NA (N) <input type="checkbox"/> Sleeping with others (O)			Temperature of area:	
Body position when placed		<input type="checkbox"/> Unk <input type="checkbox"/> Back <input type="checkbox"/> Stomach <input type="checkbox"/> Side <input type="checkbox"/> Other				
Body position when found		<input type="checkbox"/> Unk <input type="checkbox"/> Back <input type="checkbox"/> Stomach <input type="checkbox"/> Side <input type="checkbox"/> Other				
Face position when found		<input type="checkbox"/> Unk <input type="checkbox"/> To left <input type="checkbox"/> To right <input type="checkbox"/> Facedown <input type="checkbox"/> Face up <input type="checkbox"/> To side				
Nose or mouth was covered or obstructed		<input type="checkbox"/> Unk <input type="checkbox"/> No <input type="checkbox"/> Yes				
Postmortem changes when found		<input type="checkbox"/> Unk <input type="checkbox"/> None <input type="checkbox"/> Rigor <input type="checkbox"/> Lividity <input type="checkbox"/> Other				
Number of cover or blanket layers on infant: <input type="checkbox"/> Covers on infant (C) <input type="checkbox"/> Wrapped (W) <input type="checkbox"/> No covers (N)						
Sleeping or supporting surface:				Clothing:		
Other items in contact with infant:				Items in crib or immediate environment:		
Devices operating in room:		Cooling source in room:			Heat source in room:	
		<input type="checkbox"/> On (+) <input type="checkbox"/> Central (C) <input type="checkbox"/> None (N) <input type="checkbox"/> Off (-) <input type="checkbox"/> Space (S)			<input type="checkbox"/> On (+) <input type="checkbox"/> Central (C) <input type="checkbox"/> None (N) <input type="checkbox"/> Off (-) <input type="checkbox"/> Space (S)	
Item collected	Yes	No	Item collected	Yes	No	Number of scene photos taken:
Baby bottle			Apnea monitor			Other items collected:
Formula			Medicines			
Diaper			Pacifier			
Clothing			Bedding			

V. INTERVIEW AND PROCEDURAL TRACKING

Contact	Name	Date	Time	Phone	Relationship to infant
Mother					
Father					
Usual caregiver					
Last caregiver					
Placer					
Last witness					
Finder					
First responder					
EMS caller					
EMS responder					
Police					

Alternate contact person:

Phone:

Action	Date	Time	Action
Medical record review for infant			Doll reenactment performed ___ Yes ___ No
Medical record review for mother			Scene diagram completed ___ Yes ___ No
Physician or provider interview			Body diagram completed ___ Yes ___ No
Referral to social or SIDS services			Detailed protocol completed ___ Yes ___ No ___ NA
Cause of death discussed with family			Other:

VI. OVERALL PRELIMINARY SUMMARY

Notes to pathologist performing autopsy:

Indications that an environmental hazard, drug, poison, or consumer product contributed to death ___ Yes ___ No

Organ or tissue donation requested by family or agency ___ Yes ___ No ___ Unk

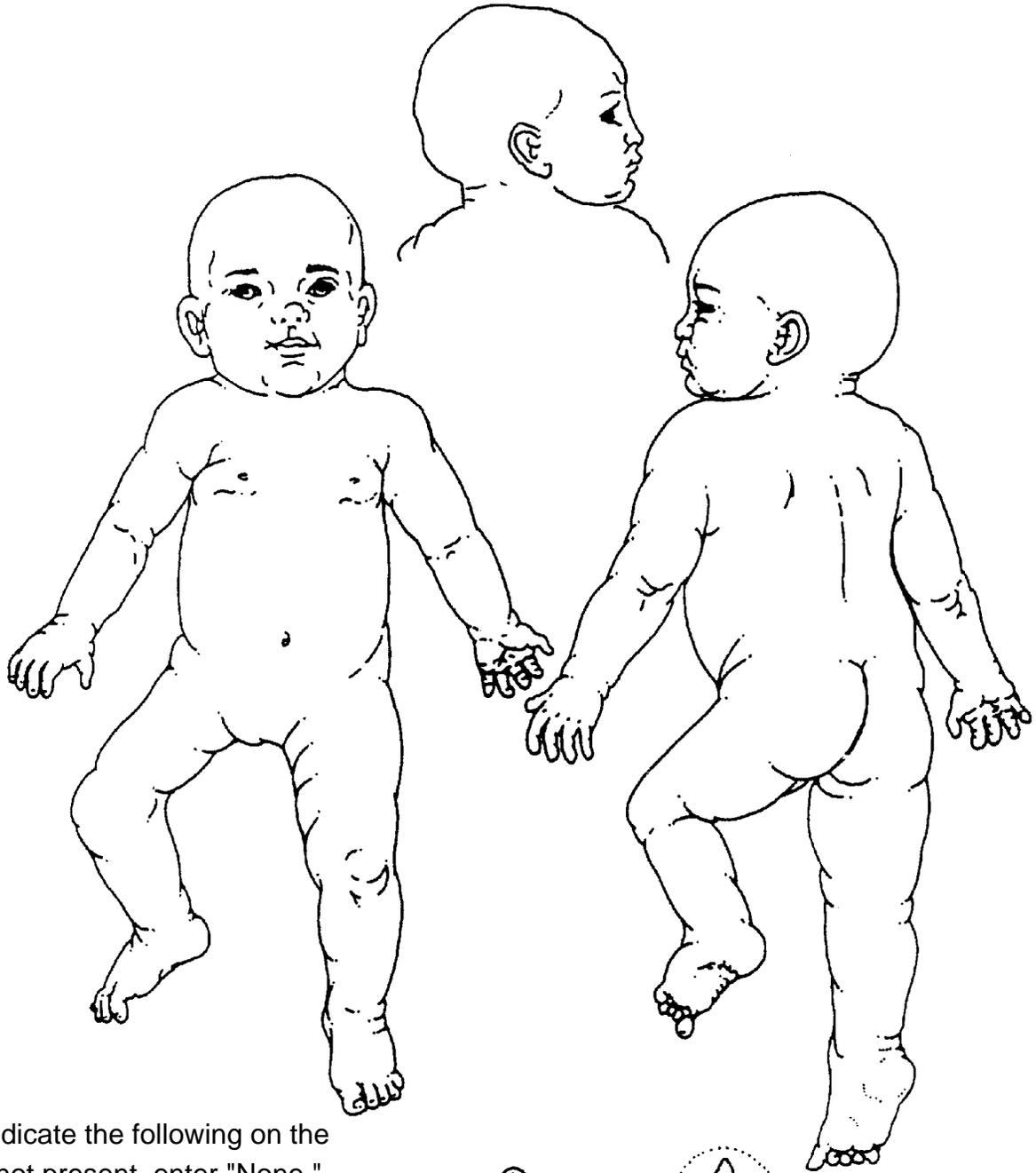
Cause of death: ___ Presumed SIDS ___ Suspect trauma or injury ___ Other

VII. CASE DISPOSITION

Case disposition	___ Case declined (D) due to ___ Topic (T) ___ Locale (L)	___ Case accepted (J) for ___ Autopsy (A) ___ Inspection (I) ___ Certification (C)
Body disposition	___ Brought in for exam (E) ___ Brought in for holding or claim (C) ___ Released from site (R)	
Who will sign DC?		
Transport agent:	Funeral home:	
Investigator and affiliation:	Date:	
	Number of supplement pages attached:	

SUIDIRF SUPPLEMENT

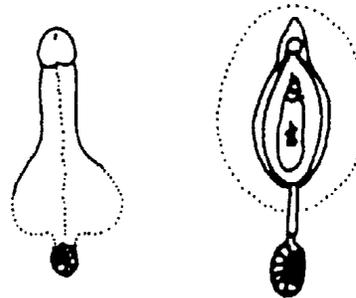
BABY DIAGRAM



Instructions

1) If present, indicate the following on the diagram. If not present, enter "None."

- _____ Drainage or discharge from body or orifices
- _____ Marks or bruises
- _____ Location of diagnostic or therapeutic devices
- _____ Pale pressure mark areas
- _____ Predominate areas of lividity



2) Complete the following:
Body temperature: _____
Source of temperature: _____